

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

 12351
 Reg. Dist. No. 168

1. PLACE OF DEATH: Garrett
 County.....
 City or town..... Route 2 Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Garrett
 City or town..... Route 2 Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME George Dewey Baker

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Margaret Baker
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) October 5 1860
 8. AGE: Years 85 Months 2 Days 23 It less than one day
 hrs. min.

9. Birthplace Pennsylvania
 (Town, county, and state)

10. Usual occupation retired miner

11. Industry or business Fire clay mines

12. Name Michael Baker

13. Birthplace Pennsylvania

14. Maiden name Carolina Bittner

15. Birthplace Pennsylvania

16. Informant Mrs. Leonard Klink

Address Route 2, Frostburg Md

17. Burial Date thereof Jan 2-1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Johnson Cemetery

Location Frostburg Md

18. Funeral director J. J. O'Leary

Address Frostburg Md

19. Jan 2 19 46 A. W. Harsh
 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 19 45 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Dec 29 19 45

and that I last saw him alive on Dec 29 19 45

Immediate cause of death.....

Senility

Due to arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Wm. J. Lane Jr. MD M. D. or other

Address Frostburg Md Date signed 12-29-45

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JAN 4 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12352

Reg. Dist. No.

163

1. PLACE OF DEATH:

County GarnettCity or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 65 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County GarnettCity or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas William

3. (b) Social Security Number

Burke4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Mary Burke7. Birth date of deceased (mo., day, yr.) Aug 15, 1848 6.(c) If alive, give age _____ years8. AGE: Years 98 Months 4 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace Ireland (Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name not known

13. Birthplace _____

14. Maiden name not known

15. Birthplace _____

16. Informant Bridgett Marie GreenAddress Bloomington, MD17. Burial Date thereof Dec 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter's ChurchLocation Westernport MD18. Funeral director E. L. Smith & SonAddress Westernport MD19. Dec. 26 19. 45 Dorsey Patterson
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945 at 12:30 P.M.21. CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 45 Dec 23 45and that I last saw him alive on Dec 23 1945

Immediate cause of death _____

Due to Chronic Pneumonia 79pDue to Aspergill 79p

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Sam & L. Paul 1945

Address _____ Date signed _____

M. D. or other _____

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DEC 27 1945
BUREAU OF
INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH:

County **Garrett**
 City or town **Kitzmiller**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **22 yrs**
 Hospital, institution, or street address where death occurred:
Church St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **Maryland** County **Garrett**
 City or town **Kitzmiller**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Church Street**
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Lawrence Mervin Cummings3. (b) Social Security Number
232-09-1643

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**
Virdella Catherine (DeWalt) Cummings

6. (b) Name of husband or wife **Cummings** 8. (c) If alive, give age **37** years7. Birth date of deceased (mo., day, yr.) **March 4, 1902**

8. AGE: Years **43** Months **9** Days **10** If less than one day
hrs.min.

9. Birthplace **Bayard, Grant Co., W.Va.**
 (Town, county, and state)
Motorman

10. Usual occupation **Coal Mines**11. Industry or business **Franklin Cummings**12. Name **Franklin Cummings**13. Birthplace **Tioga, Pa.**14. Maiden name **Lobertha Wolfe**15. Birthplace **Petersburg, W.Va.**18. Informant **Mrs. L.M. Cummings**Address **Kitzmiller, Md.****Burial** **Dec. 17 1945**

17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory **I.O.O.F. Cemetery****Elk Garden, W.Va.**Location **Otha F. Sharpless**

18. Funeral director

Address **Blaine, W.Va.**19. **12/17** 19 **45** **Cumt Barri**

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Dec. 14** **45** at **12:50 P**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 19 **45** to **Dec. 14** 19 **45**
 and last saw him alive on **Dec. 14** 19 **45**

Immediate cause of death

Acute Myocarditis **2 days**
 Due to **Bilateral Pulmonary** **?**
Suburians **?**

Other conditions **Bilateral Sclerosis**
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Ralph Colandrella M.D.**Address **Kitzmiller, Md.** Date signed **Dec. 15-45**

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 7 1946

BUREAU V A

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County GarrettCity or town Oakland,
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yearsHospital, institution, or street address where death occurred:
4th St. St. Peters RectoryHow long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland,
(If outside city or town limits, write RURAL and give nearest town)Street No. 4th Street
(If rural, give LOCATION)2.(a) If veteran, name war -----

3.(a) FULL NAME

Mary Agnes Dugan

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife -----7. Birth date of deceased (mo., day, yr.) unknown 18716.(c) If alive, give age ----- years8. AGE: Years Months Days If less than one day
about 74 hrs. min.9. Birthplace probably Baltimore, Md.
(Town, county, and state)10. Usual occupation House keeper11. Industry or business for others12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Rev. George E. ShipperAddress Oakland, Md.17. Burial Date thereof Dec. 7, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Marys CemeteryLocation Govans, Baltimore, Md.18. Funeral director Herbert P. LeightonAddress Oakland, Maryland.19. Dec 6 19 Julia Roman
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 19 45 at 6:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from examined after death 19 45and that I last saw him ----- alive on 19 45Immediate cause of death Cerebral OcclusionDue to ArteriosclerosisDue to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE D. J. Baumgartner M.D. Depty. Med.Address Oakland MD M. D. or other -----Date signed 12/5/45

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JAN 7 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH: Garrett

County.....

City or town.....Jennings
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md.....County.....Garrett

City or town.....Jennings
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs Sidney Durst

3. (b) Social Security Number

None

4. Sex.....5. Color or race.....6.(a) Single, married, widowed, or divorced

F

W

Widowed

6.(b) Name of husband or wife.....Louis Durst

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) February 13- 1864

8. AGE: Years Months Days It less than one day
81 10 11 hrs. min.9. Birthplace.....R.D.2 Grantsville Md
(Town, county, and state)

10. Usual occupation.....House Work

11. Industry or business.....

12. Name.....Samuel Custer

13. Birthplace.....Not known

14. Maiden name.....Lydia Durst

15. Birthplace.....Not known

16. Informant.....Mrs Lee Broadwater

Address.....Jennings Md

17. Burial.....Date thereof.....12-27-945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....New Germany

Location.....R.D.2 Grantsville Md

18. Funeral director.....Wm Wintersberg

Address.....Grantsville Md

19. Dec 26 45- Ethel Broadwater

(Date rec'd by registrar) 19 45- Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....December 25 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 minutes after death

and that I last saw him.....alive on 10

Immediate cause of death.....Coronary Occlusion

Due to.....Arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....Injured at work?

23. SIGNATURE.....Dallandred

Address.....Date signed.....12/25/45

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DEC 28 1945
BUREAU V D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

CERTIFICATE OF DEATH

Reg. Dist. No. 12356 166

1. PLACE OF DEATH:
County... Garrett
City or town... Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs.
Hospital, institution, or street address where death occurred:
Oak St.
How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Garrett
City or town... Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Oak Street
(If rural, give LOCATION) -----
2.(a) If veteran, name war -----

3. (a) FULL NAME
Samuel Harold Jackson

3. (b) Social Security Number
216-07-7053

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lettie Kelley Jackson

7. Birth date of deceased (mo., day, yr.) October 3, 1872 6. (c) If alive, give age 67 years

8. AGE: Years 73 Months 2 Days 27 If less than one day
hrs. min.

9. Birthplace Preston Co., W. Va.
(Town, county, and state)

10. Usual occupation Retired Superintendent

11. Industry or business Cumberland & Allegheny Gas Co.

12. Name Philip Jackson

13. Birthplace England

14. Maiden name Sophia Heidelberg

15. Birthplace Germany

16. Informant Mrs. S. H. Jackson

Address Oakland, Md.

17. Burial Date thereof Jan. 1, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Terra Alta, W. Va.

Location Terra Alta, W. Va.

18. Funeral director Herbert C. Feighston

Address Oakland, Md.

19. Jan 11 19 46 Julius Rawson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1945 at 3:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to December 1945 and that I last saw him alive on Dec. 29 19 45

Immediate cause of death Pulmonary Tuberculosis

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE D. B. Bauman M.D. M. D. or other

Address Oakland Md Date signed 12/31/45

STATE OF MICHIGAN DEPARTMENT OF CORRECTIONS

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

12357

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Crellin, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Crellin, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Asa Benjamin Johnson.

3. (b) Social Security Number

None.

4. Sex

male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married.6.(b) Name of husband or wife Virgie O. Johnson.6.(c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) June 3d, 1871

8. AGE: Years Months Days If less than one day

74625

.....hrs.min.

9. Birthplace Garrett County.
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Neil Johnson.13. Birthplace Maryland.14. Maiden name Catherine Everetts.15. Birthplace Maryland.16. Informant Edward R. Johnson.Address Tunnelton, W. Va.17. Burial Date thereof Dec. 30th/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ashby Cemetery.Location Crellin, Md.18. Funeral director Emory BoldenAddress Oakland, Md.19. Dec. 29, 45 Julius A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH December 28/45 19..... at 12:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1943 to Dec 1945and that I last saw him alive on Dec. 27 1945Immediate cause of death Carcinoma of Colon

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Benjamin, M.D. M. D. or otherAddress Oakland, Md. Date signed 12/28/45

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BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12358

Reg. Dist. No. 172

1. PLACE OF DEATH

County GarrettCity or town Shallmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Shallmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war no3. (a) FULL NAME George Washington Lechlitter3. (b) Social Security Number
None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Rebecca Catherine (Simmons) Lechlitter607. Birth date of deceased (mo., day, yr.) April 17, 1878

8. (c) If alive, give age _____ years

8. AGE: Years 67 Months 8 Days 12 If less than one day

.....hrs.min.

9. Birthplace Patterson Creek, Mineral Co., W. Va.

(Town, county, and state)

10. Usual occupation

Coal mines

11. Industry or business

John C. Lechlitter

12. Name

13. Birthplace

Cora Trenter

14. Maiden name

15. Birthplace

16. Informant Mrs. George W. LechlitterShallmar, Md.

Address

Burial17. (Burial, cremation, or removal. Which?) Date thereof Jan. 1, 1946

(month) (day) (year)

Cemetery or crematory I.O.O.F. CemeteryElk Garden, W. Va.

Location

18. Funeral director Otha F. SharplessAddress Blaine, W. Va.19. 12-31 1945 AW Banick

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945 at 8:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1940 to Dec. 29 1945and that I last saw him alive on Dec. 29 1945

Immediate cause of death

DURATION

Acute Myocarditis 2 days• Due to Arteriosclerosis ?Due to Hypertension ?Other conditions Left ventricular failuredue to chronic H. V. D. 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ralph Columbus W. D. M. D. or otherAddress 1 Cityville Rd Date signed Dec. 31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 850

CERTIFICATE OF DEATH

12359

Reg. Dist. No. 162

1. PLACE OF DEATH:

County GarettCity or town Rural Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County GarettCity or town Rural Near Grantsville Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Anthony Crescent Lewis

3. (b) Social Security Number

213-18-2602

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sara Lewis6. (c) If alive, give age 58 years

7. Birth date of

deceased (mo., day, yr.)

November 29 -1876

8. AGE:

Years

Months

Days

If less than one day

69-21

hrs.

min.

9. Birthplace New York City New York
(Town, county, and state)10. Usual occupation Coal Miner

11. Industry or business

FATHER

12. Name Newton Lewis13. Birthplace Not Known

MOTHER

14. Maiden name Not Known15. Birthplace Not Known16. Informant Mrs Sara LewisAddress R.D.2 Grantsville Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 23-1945
(month) (day) (year)Cemetery or crematory GrantsvilleLocation Grantsville Md18. Funeral director Wm WinterbergAddress Grantsville Md19. Dec 22 45
(Date rec'd by registrar)Edna Broadwater
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 45 at 4 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 1 19 45 to Dec 20 19 45
and that I last saw him alive on Dec 17 19 45

Immediate cause of death

Cerebral Hemorrhage 10 days

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

N. B. Davis M.D.
Address Grantsville Md Date signed Dec 22 45

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DEC 27 1945

BUREAU

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

12360

1. PLACE OF DEATH

County GarrettRegistration Dist. No. 167Village or City Kempton

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME James Issac McMANUS

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Bertie May Ashfield6. DATE OF BIRTH (month, day, and year) June 14, 1871

7. AGE Years Months Days IF LESS than
74 5 20 1 day, _____ hrs.
or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Miner

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Franklin
(State or country) Allegheny Co., Md.

13. NAME Joseph Mc Manus

14. BIRTHPLACE (city or town) Unknown
(State or country)

15. MAIDEN NAME Unknown Smith

16. BIRTHPLACE (city or town) Unknown
(State or country)

17. INFORMANT Ray Mc Manus
(Address) Kempton, West Va.

18. BURIAL, CREMATION, OR REMOVAL
Place Bayard, W. Va. Date Dec. 7, 1945

19. UNDERTAKER Thomas, West Va.
(Address)

20. FILED 12/18, 1945 Elmer C. Shaffer
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

December 4, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1945, to Dec 4, 1945

I last saw him alive on Dec 4, 1945; death is said to have occurred on the date stated above, at 8:30 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

myocarditis + Endocarditis

Date of onset

Other Contributory Causes of importance

arteriosclerosis and coronary occlusion

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) C. P. Burke M. D.

(Address) Thomas, West Va.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH

County Garrett
 City or town Kitzmilller
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs.
 Hospital, institution, or street address where death occurred:
Spring St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Kitzmilller
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Spring Street
 (If rural, give LOCATION)
 2.(a) If veteran, name War

3. (a) FULL NAME

Stella Francis McRobie3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Joseph Francis McRobie
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug. 26, 1865
 8. AGE: Years 80 Months 3 Days 16 If less than one day _____ hrs. _____ min.

8. Birthplace Deer Park, Garrett Co., Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Own Home
 12. Name Abraham McRobie
 13. Birthplace
 14. Maiden name Nancy Catherine Friend
 15. Birthplace

16. Informant Mrs. Stella Rohrbaugh
Kitzmilller, Md.
 Address
 17. Burial Date thereof Dec. 14, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory I.O.O.F. Cemetery
Elk Garden, W.Va.
 Location
 18. Funeral director Otha F. Sharpless
Blaine, W.Va.
 Address
 19. 12/14 45 C. W. B. B. B.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 45 10:10A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1940 to Dec. 12 1945
 and that I last saw him alive on Dec. 12 1945
 Immediate cause of death Coronary Thrombosis
Arrhythmia fibrillata
 Due to Hypertension
 Other conditions Smoking
 (Include pregnancy within 8 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Ralph Calamagallo M.D.
Kitzmilller, Md.
 Address Date signed 12-13-45

RECEIVED
JAN 7 1946
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 1236266

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland,
 (If outside city or town limits, write RURAL and give nearest town)
Life time
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Harold Esmond Miller.

3. (b) Social Security Number

220-10-2839

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.
 6.(b) Name of husband or wife Etta Cogley Miller.
 6.(c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) June 19th 1877
 8. AGE: Years 68 Months 5 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace West Virginia.
 (Town, county, and state)
 10. Usual occupation Stone Mason
 11. Industry or business _____

12. Name James G. Miller.
 13. Birthplace West Virginia.
 14. Maiden name Melissa L. Hewitt.
 15. Birthplace West Virginia.

16. Informant Mrs. Etta Miller.
 Address Oakland, Md.
 17. Burial Date thereof December 14/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oakland, Cemetery.
 Location Oakland, Md.

18. Funeral director Emory D. Pollock
 Address Oakland, Md.
 19. Dec 13 45 Julius Korman Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

P.M

20. DATE OF DEATH December 11th 45 at 5:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28, 45 to December 10, 45
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Coronary Occlusion

DURATION

Due to Myocardial Infarction
 Due to Arteriosclerosis

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Andrew E. Thomas MD
101 Third Street
Oakland, Md. M. D. or other _____
 Address _____ Date signed 12/13/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
DEC 19 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1193

CERTIFICATE OF DEATH

Reg. Dist. No. 12363 166

1. PLACE OF DEATH:

County GarrettCity or town Swanton Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 mo.Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Rural Swanton
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 Mi. East Swanton
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Gary Williams Paugh

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife -----

7. Birth date of deceased (mo., day, yr.) February 20, 1945

6. (c) If alive, give age ----- years

8. AGE: Years -- Months 10 Days 11 If less than one day
----- hrs. ----- min.9. Birthplace Garrett Co., Md.
(Town, county, and state)

10. Usual occupation -----

11. Industry or business -----

FATHER 12. Name Charles L. Paugh13. Birthplace Bloomington; Garrett Co., Md.MOTHER 14. Maiden name Bessie Virginia Kitzmiller15. Birthplace Harrison, W. Va.16. Informant Charles L. PaughAddress Vindex, Md.17. Burial Date thereof Jan. 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Zion CemeteryLocation 6 Mi. So. Swanton, Md.18. Funeral director Herbert C. LeightonAddress Oakland, Md.19. Jan 2 '46 Julia Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1945 at 3:35 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-24-45 to 12-31-45and that I last saw him alive on 12-24-45Immediate cause of death Acute Bronchitis
and DiarrheaDURATION
1 week

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? -----
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Julia Rowan M. D. or otherAddress Oakland, Maryland Date signed 1-1-46

MASSACHUSETTS STATE CHARTER

RECEIVED

RECEIVED

JAN 28 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 12364 6

1. PLACE OF DEATH.

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
20 yrs.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -----
 (If rural, give LOCATION)
 2.(a) If veteran, name war -----

3.(a) FULL NAME

Susie Lovina Roy

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife James Richard Roy6.(c) If alive, give age 77 years7. Birth date of deceased (mo., day, yr.) September 26, 1878

8. AGE: Years 67 Months 2 Days 14 If less than one day
 ----- hrs. ----- min.

9. Birthplace Garrett Co., Md.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business Own Home12. Name George W. Fulmer13. Birthplace Ohio.14. Maiden name Jennie Green15. Birthplace Mineral Co., W. Va.16. Informant Mrs. Richard Roy Jr.Address Mt. Lake Park, Md.17. Burial Date thereof Dec. 13, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pleasant Valley CemeteryLocation 2 Mi. So. Oakland Md.18. Funeral director Herbert P. ReightonAddress Oakland, Md.19. Dec 12 19 45 Julius Rowan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1945 at 2:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

----- 19----- to ----- 19-----

and that I last saw him ----- alive on ----- 19-----

Immediate cause of death Coronary OcclusionDue to Arterio Sclerosis

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE J. S. Thomas MD

M. D. or other

Address Oakland Md Date signed 12/14/45

WESTERN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF BIRTH

RECEIVED

JAN 7 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12365/62

1. PLACE OF DEATH:

County... GarettCity or town... Grantsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... GarettCity or town... Rural Near Jennings Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Harriet Jane Stahl

3.(b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife George Stahl7. Birth date of deceased (mo., day, yr.) August 31 1864

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

8139

..... hrs. min.

9. Birthplace Jennings Md Garrett Co

(Town, county, and state)

10. Usual occupation House Work

11. Industry or business

12. Name Jonas J. Folk13. Birthplace Springs Pa14. Maiden name Susan Shultz15. Birthplace Somerset Co Pa16. Informant Harry StahlAddress Grantsville Md17. Burial Date thereof 12-12-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GrantsvilleLocation Grantsville Md18. Funeral director Miss M. WinterbergAddress Grantsville Md19. Dec 11 1945 Ethel Broduski

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1945 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 1945 to Dec 9 1945and that I last saw her alive on Dec 5 1945Immediate cause of death Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE M. D. Davis M.D.M. D. or PhysicianAddress Grantsville Date signed Dec 9 1945

RECEIVED

DEC 12 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

Reg. Dist. No. 12366 166

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Oakland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Owen Thomas Treacy.

3. (b) Social Security Number

home

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.
 6. (b) Name of husband or wife Mrs. Mary Sweeney Treacy
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 15th, 1873.
 8. AGE: Years 72 Months 9 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Ireland.
 (Town, county, and state)
 10. Usual occupation Merchant.
 11. Industry or business _____
 FATHER 12. Name James Treacy, Sr.
 13. Birthplace Ireland.
 MOTHER 14. Maiden name Bridget Boyle.
 15. Birthplace Ireland.

16. Informant Mrs. Mary Treacy.
 Address Oakland, Md.

17. Burial Date thereof December 7/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Peter Cemetery.
 Location Oakland, Maryland.

18. Funeral director Emory D. Belding
 Address Oakland, Md.

19. Dec 6 19 45 John Karon
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945 at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1936 to Dec 4 1945
 and that I last saw him alive on Dec. 4 1945

Immediate cause of death Chronic Myocarditis
 Due to arteriosclerosis
 Due to _____
 Other conditions Ischemic by pathology
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE E. J. Baumgartner M.D.
 Address Oakland, Md. Date signed 12/6/45
 M. D. or other _____

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

DEC 19 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84)

CERTIFICATE OF DEATH

12367 166

★ Reg. Dist. No.

1. PLACE OF DEATH:

County GarrettCity or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland, County GarrettCity or town Crellin, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Minrow Uphold.

3. (b) Social Security Number

078-05-1120

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Widower</u>

6. (b) Name of husband or wife Maud E. Lambert Uphold.
Deceased7. Birth date of deceased (mo., day, yr.) February 1st, 1882.
S. (c) If alive, give age years

8. AGE:	Years	Months	Days	It less than one day
	<u>63</u>	<u>10</u>	<u>10</u> hrs. min.

9. Birthplace Maryland.
(Town, county, and state)10. Usual occupation Miner

11. Industry or business

12. Name Clay Uphold.13. Birthplace Maryland.14. Maiden name Sarah McCabe.15. Birthplace Maryland.16. Informant Mrs. Beatrice Holler.Address Oakland, Md.17. Burial Date thereof December 13/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ashby Cemetery.Location Crellin, Md.19. Funeral director Ernest D. BoldenAddress Oakland, Md.19. Dec 13 1945 Julius A Kowan
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH December 11th 1945 at 5:40 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27, 1945 to December 11 1945and that I last saw him alive on December 10, 1945Immediate cause of death Broncho pneumonia

DURATION

4 daysDue to PolyneuritisDue to Lateral Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest D. Bolden M. D. or otherAddress Oakland, Md. Date signed 12/13/45

CERTIFICATE OF DEATH

RECEIVED
DEC 19 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 168

1. PLACE OF DEATH:

County GarettCity or town Pinzel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County GarettCity or town Jennings Md
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Christ Yommer

3. (b) Social Security Number

313-18-2588

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Susie Yommer6. (c) If alive, give age 35 56 years7. Birth date of deceased (mo., day, yr.) June 3-18818. AGE: Years Months Days If less than one day
64 6 - hrs. min.9. Birthplace Jennings Md
(Town, county, and state)10. Usual occupation Lumber Sawyer

11. Industry or business

FATHER 12. Name George Yommer
13. Birthplace GermanyMOTHER 14. Maiden name Elizabeth Witzgall
15. Birthplace Germany16. Informant Mrs Susie Yommer
Address Jennings Md17. Burial Date thereof 12-6-1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GrantsvilleLocation Grantsville Md19. Funeral director Wm Winterberg
Address Grantsville Md19. Dec. 5 45 Michael
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH December 3rd. 19 45 at 5.20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Brown M.D.Address Cumberland, Maryland Date signed 12-3-45County Medical Examiner Allegany Co.

RECEIVED
DEC 7 1945
BUREAU V S